BEFORE THE APPEALS BOARD
FOR THE
KANSAS DIVISION OF WORKERS COMPENSATION

DAVID D. HUGHES Claimant	)	
VS.	)	
PANERA BREAD Respondent	)	Docket No. 1,044,250
AND	)	
CONTINENTAL WESTERN INS. CO. Insurance Carrier	)	

ORDER

STATEMENT OF THE CASE

Respondent and its insurance carrier (respondent) requested review of the June 25, 2010, Award entered by Administrative Law Judge Rebecca A. Sanders. The Board heard oral argument on January 12, 2011.[1] Acting Director Seth G. Valerius appointed Thomas D. Arnhold to serve as a Board Member Pro Tem in this case.[2] George H. Pearson, of Topeka, Kansas, appeared for claimant. Nathan D. Burghart, of Lawrence, Kansas, appeared for respondent.

The Administrative Law Judge (ALJ) found that claimant was entitled to an impairment to the body as a whole and to a work disability. The ALJ found that claimant had a task loss of 24 percent. The ALJ further found that claimant had a wage loss of 100 percent from September 7, 2008, to May 1, 2009, which computed to a 62 percent work disability; a wage loss of 68 percent from May 1, 2009, through January 1, 2010, which computed to a 46 percent work disability; and a wage loss of 100 percent after January 1,

[1] This appeal was originally scheduled for oral argument on October 20, 2010. But because of the retirement of Board Member Carol Foreman, it could not be heard on that date. K.S.A. 44-555c(k) requires all five members of the Board to participate in every decision. A Board Member Pro Tem was not appointed by the Acting Director until December 21, 2010.

[2] Mr. Arnhold has since become a full member of the Workers Compensation Board.

2010, which computed to a 62 percent work disability. The ALJ did not make a finding as to claimant's percentage of functional impairment.

The Board has considered the record and adopted the stipulations listed in the Award, other than Stipulation No. 8. The Stipulation filed by the parties on May 18, 2010, states that claimant's base average weekly wage at the time of his injury was $625, excluding fringe benefits. The weekly cost of fringe benefits to respondent was $58.90. Fringe benefits were terminated on or about March 31, 2009. Therefore, claimant's average weekly wage from the date of the accident through March 31, 2009, would be $625, and thereafter his average weekly wage would be $683.90, as it would include the respondent's weekly costs for fringe benefits. Also, during oral argument to the Board, the parties agreed to the functional impairment and task loss opinions given by Dr. Pratt of 12 percent to the knee, 5 percent to the back, if the back is found compensable, and a 24 percent task loss, if claimant is found to be entitled to an award of work disability. The parties further agreed to introduce the April 22, 2009, letter by Mr. Pearson to Dr. Murati.

ISSUES

Respondent requests review of the ALJ's findings regarding the nature and extent of claimant's disability. Respondent argues that claimant has not proven that he suffered a whole body disability and is not entitled to a work disability. Respondent also argues that claimant should be limited to a functional disability of the right lower extremity.

Claimant asks that the Board affirm the Award in its entirety.

The issue for the Board's review is: What is the nature and extent of claimant's disability?

FINDINGS OF FACT

Claimant began working for respondent in July 2007 as an assistant manager. On September 6, 2008, claimant was walking out of a walk-in cooler when he slipped on the wet floor and fell. Claimant said his feet flew out from under him, and he landed on his left hip. At the time, claimant felt pain in his left hip and right knee. He went to the emergency room that day, where he told the emergency room doctors that he was having problems with his right knee. An x-ray of his right knee was normal. He was later seen by Dr. Donald Mead of St. Francis Occupational Medicine. Claimant testified that his hip pain eventually resolved.

Claimant testified that several weeks after the accident, he developed an altered gait, which caused him low back pain. He admits that at no time did he make any complaint to Dr. Mead concerning his low back, and Dr. Mead did not treat claimant for any

back problem. Claimant testified that he did not believe his low back was hurting him during the time he was seeing Dr. Mead.

An MRI of claimant's right knee was done at Dr. Mead's request on October 16, 2008, which was read to show claimant had a complex radial tear through the posterior horn meniscus. Dr. Mead referred claimant to Dr. Peter Lepse, a board certified orthopedic surgeon. Claimant's initial visit with Dr. Lepse was on November 17, 2008. Dr. Lepse said that at the initial visit, claimant made no complaints other than the area of his right knee. Dr. Lepse performed an examination. Pertinent findings included tenderness along the posteromedial joint line on the right knee. Claimant did not exhibit any limp and was able to stand erect with good posture and balance. Dr. Lepse advised claimant to undergo arthroscopy with probable meniscectomy.

Dr. Lepse performed surgery on claimant's right knee on January 23, 2009. At the time of the surgery, the most notable finding was a wear on claimant's kneecap, or chondromalacia, which is a degenerative condition. Dr. Lepse performed a chondroplasty, removing loose flaps that tend to catch and trigger pain. Claimant was also found to have chondromalacia affecting the medial condyle and a small tear in his lateral meniscus. Dr. Lepse said he could not specifically attribute the arthroscopic findings to the fall at work. He said, "In my view, it's much more likely that the findings developed over time due to his weight."[3] He said that it was probable the fall aggravated claimant's preexisting knee condition.

During the surgery, Dr. Lepse found that claimant did *not* have a tear in the posterior horn of the medial meniscus, as was the reading of the October 2008 MRI, so the MRI reading was a false positive. The tear in the meniscus was on the lateral side of the joint. Dr. Lepse said he could not determine the cause of the tear, but the tear could have been contributed to by claimant falling and landing on his right knee and left hip.

Claimant was seen by Dr. Lepse on March 2, 2009, at which time he gave claimant a slip indicating he could return to full duty on March 16, 2009. Claimant states he did not see this slip and did not realize he was to return to work. At the March 2, 2009, examination, Dr. Lepse noted that claimant's gait was slightly antalgic. He was last seen by Dr. Lepse on April 13, 2009. He was given no specific treatment on that date, but x-rays were taken to evaluate his symptoms. Dr. Lepse checked claimant's gait and stance and found them to be normal. Claimant was advised to return to full duty work the next day, April 14, 2009. Dr. Lepse did not impose any permanent restrictions on claimant.

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[3] Lepse Depo. at 18. Claimant's weight at the time of the accident was approximately 360 pounds, and at times during his treatment and examinations was as high as 425 pounds. Claimant is 6 foot 2 inches tall.

When claimant tried to return to work, no one from respondent would speak to him, and he was told all contact was to be made through his workers compensation representative. Claimant learned he had been terminated for failing to report to work on March 16, 2009.

Dr. Lepse stated that at no time during the course of his treatment did claimant report complaints of low back problems. Claimant never voiced any complaint other than to his right knee. Dr. Lepse testified that if a patient made a complaint of low back pain, Dr. Lepse would note that in his records and would have referred the patient to another doctor for appropriate care, as he does not treat backs. Claimant, however, testified that he told Dr. Lepse about his back problems. Claimant said that after his surgery, his altered gait improved, but his low back pain continued to worsen.

Because Dr. Lepse does not do impairment ratings, claimant was referred by respondent to one of Dr. Lepse's partners, Dr. John Gilbert, for examination and an impairment rating. Dr. Gilbert is board certified in orthopedic surgery and independent medical examination. He examined claimant on May 20, 2009. Claimant told Dr. Gilbert that on September 6, 2008, he slipped on a wet floor and landed on his left hip and buttocks, then felt a pop and had pain in his right knee. Claimant told Dr. Gilbert he still experienced pain, particularly with trying to climb stairs or squat. He said he was able to walk without great discomfort. He did not experience locking or buckling of his knee. Dr. Gilbert had no record that claimant complained to him of any sort of low back problem, nor did he find any evidence of back complaints in the medical records.

Dr. Gilbert said claimant limped a little because he had an arthritic knee. He said x-rays dated April 13, 2009, showed claimant had good preservation of the tibiofemoral and patellofemoral joint spaces on the right. There was mild joint space narrowing in the medial joint compartment on the left when compared to the right. An MRI of the right knee done October 16, 2008, showed a radial tear of the medial meniscus, evidence of a small effusion, and some popliteal cysts. At claimant's height of 6 foot 2 inches and weight of 420 pounds, Dr. Gilbert said claimant would be considered morbidly obese, which would put him at a high risk for degenerative conditions in the lower extremity and weight bearing joints, as well as mechanical and degenerative problems in the spine.

Dr. Gilbert diagnosed claimant with a torn lateral meniscus in the right knee and degenerative joint disease in the knee with chondromalacia of the medial femoral status condyle and patella, status post arthroscopy with lateral meniscectomy and debridement of chondromalacia of the medial femoral condyle and patella.

Using the AMA *Guides*,[4] Dr. Gilbert found that claimant had a 10 percent impairment to the right lower extremity as a result of lack of full flexion, and 20 percent impairment to the right lower extremity as a result of flexion contracture of 10 degrees. These combined for an impairment of 28 percent to the right lower extremity for loss of range of motion in the right knee. Dr. Gilbert opined that half of that impairment, 14 percent, was a result of preexisting degenerative disease and claimant's excessive weight, and 14 percent was the result of the injury of September 6, 2008. Dr. Gilbert found claimant had a 2 percent impairment for the partial lateral meniscectomy, which combined with the 14 percent impairment for loss of motion for a total impairment of 16 percent to the right lower extremity. Dr. Gilbert said he ascribed the entire meniscal injury impairment to the accident in September 2008. Dr. Gilbert was not asked to evaluate the low back.

Dr. Gilbert said claimant was released by Dr. Lepse to full duty without restrictions. He did not review a task list but said he would not restrict claimant from performing any of his prior job tasks, with the possible exception of extremes of certain activities. He recommended that claimant avoid a lot of ladders and stairs.

Dr. Pedro Murati is board certified in physical medicine and rehabilitation, electrodiagnosis, and independent medical evaluations. He examined claimant on May 14, 2009, at the request of claimant's attorney. Dr. Murati took a history from claimant and reviewed his past medical records. Claimant told him he slipped and fell on a wet tile floor, landing on his left hip. Dr. Murati said the fall caused claimant's low back to twist and also injured claimant's right knee. Claimant told Dr. Murati that he has continuous pain in his left hip, he cannot stand for long periods of time, has low back pain, is not able to go up or down stairs, has pain in his right leg, and has numbness in both feet.

After examining claimant, Dr. Murati diagnosed claimant with low back pain with signs and symptoms of radiculopathy secondary to antalgic gait, status post right knee arthroscopy with chondoplasty of the patella and medial femoral condyle and arthroscopic partial lateral meniscectomy, and right SI joint dysfunction. Claimant denied he had previous back problems.

Based on the AMA *Guides*, Dr. Murati rated claimant with a 10 percent whole person impairment for low back pain with signs and symptoms of radiculopathy, putting claimant into Lumbosacral DRE III. For status post right knee arthroscopic partial lateral meniscectomy, he rated claimant with a 2 percent impairment to the right lower extremity. For right knee flexion contracture, he rated claimant with a 20 percent impairment to the right lower extremity. The ratings to the right lower extremity combined for a 22 percent right lower extremity impairment, which converts to a 9 percent whole person impairment.

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[4] American Medical Association, *Guides to the Evaluation of Permanent Impairment* (4th ed.). All references are based upon the fourth edition of the *Guides* unless otherwise noted.

This, when combined with the 10 percent impairment to the body as a whole for claimant's low back, gives claimant a total of 18 percent impairment to the body as a whole.

Dr. Murati recommended permanent restrictions to claimant. In an eight-hour day, he recommended that claimant not climb ladders, squat, crawl, drive a manual transmission, kneel, or use repetitive foot controls. Claimant was restricted from lifting, carrying, pushing and pulling to under 35 pounds and then only occasionally. He should rarely stand, walk, bend, crouch, stoop, or use stairs. He could frequently lift, carry push and pull to 20 pounds. He should not lift from below knuckle height. Dr. Murati said essentially, claimant needs a sit-down job.

Dr. Murati believed claimant developed an altered gait which led to the back problems. Dr. Murati had been provided records from Drs. Mead, Lepse, Gilbert and Prostic. He admitted that in none of the medical records did he see any indication that claimant had any treatment or testing in regard to his back. According to Dr. Murati's report, claimant told him his back pain started the day of the accident. When told that claimant testified his back pain started several weeks after the accident, Dr. Murati explained that claimant had back pain initially from the accident that went away.

Dr. Murati said there was no question in his mind that claimant had signs and symptoms of radiculopathy. Dr. Murati said that claimant did not have nerve conduction testing, nor did he have an MRI, x-ray or other testing for his back. Dr. Murati said the AMA *Guides*, in order to rate a claimant for radiculopathy, sets out that the claimant must have "significant signs of radiculopathy, such as loss of relevant reflex(es) or measured unilateral atrophy of greater than 2 cm above or below the knee, compared to measurements of the contralateral side at the same location. The impairment may be verified by electrodiagnostic findings."[5] Dr. Murati said that in his physical examination of claimant, he found claimant was missing a left ankle reflex. He also said claimant showed a loss of sensation along the left L5 dermatome and weak bilateral great toe extensors. Dr. Murati said all were signs of radiculopathy.

Dick Santner, a vocational rehabilitation counselor, met with claimant on May 7, 2009.[6] Together they identified 33 tasks claimant performed in the 15-year period before his injury. Dr. Murati reviewed the task list prepared by Mr. Santner and opined that of the 33 tasks on the list, claimant is unable to perform 21 for a 63.6 percent task loss.

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[5] AMA *Guides* at 102; see Murati Depo. at 24.

[6] Michelle Sprecker, a vocational rehabilitation counselor, met with claimant on March 15, 2010, at the request of respondent. She prepared a list of 48 tasks that claimant performed in the 15-year period before his accident. Her list was not supplied to any of the physicians for a task loss opinion.

Dr. Terrence Pratt, who is board certified in physical medicine and rehabilitation, performed an independent medical examination of claimant on November 2, 2009, at the request of the ALJ. Claimant gave Dr. Pratt a history of his accident and medical treatment, and Dr. Pratt reviewed copies of his medical records. His chief complaints were right knee, low back and left hip discomfort. He described his right knee pain as intermittent with shooting anteriorly when on stairs. He complained of diminished range of motion and said he could not squat. He said the knee locks or catches occasionally, but that diminished after his surgery, although he said it gave away a few times, resulting in falls with no injuries. Claimant's hip symptoms are in the left gluteal region with near continuous aching pain.

Claimant described his low back to Dr. Pratt as becoming the worst area of involvement, with intermittent burning starting in the region of the left sacroiliac joint radiating across the low back with symptoms after standing more than 10 minutes. Claimant had no true radicular type symptoms, but he had weakness, left greater than right, in his lower extremity and numbness in the lateral aspect of the left foot. He told Dr. Pratt that his low back pain developed a few weeks after the event, and he attributed it to an altered gait. Dr. Pratt did not remember seeing anything in claimant's medical records indicating a low back problem, except in Dr. Murati's report.

After examination, Dr. Pratt diagnosed claimant with low back pain with findings suggestive of sacroiliac dysfunction, left, and status post arthroplastic chondroplasty patella and medial femoral condyle and partial lateral meniscectomy. Regarding causation, Dr. Pratt stated that claimant had involvement of his right knee in relation to the slip and fall in September 2008. However, he said there was no radiographic evidence or other significant documentation that would confirm an injury to the low back or spine that resulted from the accident. Further, Dr. Pratt noted that during claimant's preoperative physical on January 16, 2009, he reported that he was having hip pain, but stated it was the right hip, and he reported landing on his buttocks.

Dr. Pratt agreed that claimant would be considered morbidly obese. He believes that claimant's weight could contribute to his low back pain. An altered gait could also contribute to back pain. At the time Dr. Pratt examined claimant, claimant's gait was slow but otherwise normal. Dr. Pratt noted in his report that "significant gait impairment was not identified."[7] By this, Dr. Pratt meant that claimant was not limping significantly, but he had some limited range of his knee and he was slow with ambulation. But at least on flat or level surfaces, a significant gait alteration was not identified.

Dr. Pratt was told claimant testified that following the surgery for his knee, his limp got better but his low back pain has continued to worsen. Dr. Pratt testified: "Symptoms

[7] Pratt Depo., Ex. 2 at 4.

progressing with resolution of the altered gait would suggest that the low back pain is from another cause."[8] Without radiograph studies, Dr. Pratt said he would not be able to say with certainty the cause of claimant's low back pain. He agreed, nevertheless, that a person of claimant's weight falling on his back could and probably would aggravate a preexisting low back condition.

Dr. Pratt noted that Dr. Mead's office note of September 29, 2008, and Dr. Lepse's office note of November 17, 2008, both reflect that claimant's gait and stance were normal. Dr. Lepse's office note of April 13, 2009, also notes claimant had a normal gait. It had been Dr. Pratt's understanding, based on claimant's history, that within a few weeks after the injury, claimant developed low back pain related to an altered gait. Dr. Pratt testified:

> Without any radiographic studies, I could not say to a significant degree of medical certainty that he developed low back pain in direct relationship to his reported event. There's potential for preexisting involvement of the region which has not been evaluated.[9]

In relation to claimant's low back, Dr. Pratt placed him in the AMA *Guides* DRE Lumbosacral Category II, resulting in a 5 percent permanent partial impairment to the body as a whole. Regarding claimant's right knee, for limitations in extension, he rated claimant as having a 20 percent impairment of the right lower extremity. For the partial meniscectomy, claimant received an additional 2 percent impairment to the right lower extremity. The total impairment to the right lower extremity was 22 percent, of which Dr. Pratt apportioned 10 percent to preexisting involvement. The remaining 12 percent impairment to the right lower extremity converts to a 5 percent rating to the body as a whole. This would combine with the 5 percent for the low back to result in a total impairment of 10 percent to the whole body.

Dr. Pratt indicated that claimant's fall could have aggravated a preexisting back problem. However, he testified that within a reasonable degree of medical probability, claimant's 5 percent whole person impairment for his lumbosacral condition was a result of his altered gait.

Dr. Pratt did not place any permanent restrictions on claimant's ability to return to work. Nevertheless, Dr. Pratt reviewed the task list prepared by Mr. Santner. Of the 33 tasks on the list, he opined that claimant was unable to perform 8 for a 24 percent task loss. He eliminated tasks that required climbing, frequent stooping and lifting and carrying over 100 pounds.

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[8] Pratt Depo. at 14.

[9] Pratt Depo. at 19.

Claimant was terminated by respondent on or about March 31, 2009, when he did not return to work after being released by Dr. Lepse to return to work on March 16. From May 1, 2009, until January 2010, claimant worked part-time for his brother answering the phone. He earned $200 per week with no fringe benefits. Since January 2010, when claimant's brother stopped paying him to answer the telephone, claimant's wage loss has been 100 percent.

PRINCIPLES OF LAW

K.S.A. 2010 Supp. 44-501(a) states in part: "In proceedings under the workers compensation act, the burden of proof shall be on the claimant to establish the claimant's right to an award of compensation and to prove the various conditions on which the claimant's right depends."

K.S.A. 2010 Supp. 44-508(g) defines burden of proof as follows: "'Burden of proof' means the burden of a party to persuade the trier of facts by a preponderance of the credible evidence that such party's position on an issue is more probably true than not true on the basis of the whole record."

K.S.A. 44-510d states in part:

> (a) Where disability, partial in character but permanent in quality, results from the injury, the injured employee shall be entitled to the compensation provided in K.S.A. 44-510h and 44-510i and amendments thereto, but shall not be entitled to any other or further compensation for or during the first week following the injury unless such disability exists for three consecutive weeks, in which event compensation shall be paid for the first week. Thereafter compensation shall be paid for temporary total loss of use and as provided in the following schedule, 66 2/3% of the average gross weekly wages to be computed as provided in K.S.A. 44-511 and amendments thereto, except that in no case shall the weekly compensation be more than the maximum as provided for in K.S.A. 44-510c and amendments thereto. If there is an award of permanent disability as a result of the injury there shall be a presumption that disability existed immediately after the injury and compensation is to be paid for not to exceed the number of weeks allowed in the following schedule:
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> . . . .
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> (16) For the loss of a leg, 200 weeks.
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> . . . .
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> (23) Loss of a scheduled member shall be based upon permanent impairment of function to the scheduled member as determined using the fourth edition of the American Medical Association Guides to the Evaluation of Permanent Impairment, if the impairment is contained therein.

K.S.A. 44-510e states in part:

> Permanent partial general disability exists when the employee is disabled in a manner which is partial in character and permanent in quality and which is not covered by the schedule in K.S.A. 44-510d and amendments thereto. The extent of permanent partial general disability shall be the extent, expressed as a percentage, to which the employee, in the opinion of the physician, has lost the ability to perform the work tasks that the employee performed in any substantial gainful employment during the fifteen-year period preceding the accident, averaged together with the difference between the average weekly wage the worker was earning at the time of the injury and the average weekly wage the worker is earning after the injury. In any event, the extent of permanent partial general disability shall not be less than the percentage of functional impairment. Functional impairment means the extent, expressed as a percentage, of the loss of a portion of the total physiological capabilities of the human body as established by competent medical evidence and based on the fourth edition of the American Medical Association Guides to the Evaluation of Permanent Impairment, if the impairment is contained therein. An employee shall not be entitled to receive permanent partial general disability compensation in excess of the percentage of functional impairment as long as the employee is engaging in any work for wages equal to 90% or more of the average gross weekly wage that the employee was earning at the time of the injury.

An accidental injury is compensable under the Workers Compensation Act even where the accident only serves to aggravate a preexisting condition.[10] The test is not whether the accident causes the condition, but whether the accident aggravates or accelerates the condition.[11] An injury is not compensable, however, where the worsening or new injury would have occurred even absent the accidental injury or where the injury is shown to have been produced by an independent intervening cause.[12]

ANALYSIS

It is perplexing that claimant would report back pain to Dr. Murati on May 14, 2009, but not report back problems to Dr. Gilbert six days later on May 20, 2009.[13] Nevertheless, the absence of back complaints to Dr. Gilbert is consistent with the records of the treating physicians. Claimant had seen Dr. Lepse as recently as April 14, 2009, and voiced no back complaints, according to the doctor's records. And Dr. Lepse testified that if a patient makes a complaint of back pain he would note that in his records. At the time of his last

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[10] *Odell v. Unified School District*, 206 Kan. 752, 758, 481 P.2d 974 (1971).

[11] *Woodward v. Beech Aircraft Corp.*, 24 Kan. App. 2d 510, Syl. ¶ 2, 949 P.2d 1149 (1997).

[12] *Nance v. Harvey County*, 263 Kan. 542, 547-50, 952 P.2d 411 (1997).

[13] Claimant filed K-WC E-1, Application for Hearing, on February 11, 2009, alleging injury to his right knee, left hip and low back.

examination of claimant after his knee surgery, Dr. Lepse checked claimant's gait and stance and found them to be normal. Dr. Gilbert did not examine claimant's back but he did notice that claimant had a slight limp. Dr. Murati, conversely, examined claimant's back and rated it as a 10 percent impairment. Although claimant told Dr. Murati that he injured his back in the slip and fall at work on September 6, 2008, Dr. Murati attributed claimant's back impairment to an altered gait. The altered gait was attributed to the knee injury.

When claimant was examined by Dr. Pratt on November 2, 2009, he described low back complaints, including pain which he described as developing a few weeks after his slip and fall and as a result of an altered gait. Dr. Pratt did not relate claimant's back complaint to the fall but said an altered gait could contribute to back pain. Dr. Pratt said claimant's gait was slow, but he did not, however, find a significant limp. Dr. Pratt said that a significant gait impairment was not identified. The answers that Dr. Pratt gave about the low back being related to a fall and an aggravation of a preexisting condition were based on hypothetical questions that were not consistent with the facts of this case. He seemed to believe claimant's back problems were due to some cause other than the fall or a limp due to the knee injury. But ultimately, and somewhat inconsistently, Dr. Pratt said that his 5 percent rating to the low back was a result of claimant's altered gait.[14] Nevertheless, based on the absence of low back complaints to the treating physicians and the inconsistent or intermittent appearance of an altered gait, the Board finds that claimant has not proven a work-related back injury.

The Board finds that claimant has proven a permanent impairment of function to his right knee. Pursuant to the parties' stipulation, the Board finds claimant's permanent impairment is 12 percent to his right lower extremity at the level of the leg.

CONCLUSION

Claimant is entitled to an award of permanent partial disability compensation based upon a 12 percent permanent impairment of function to the leg.

AWARD

WHEREFORE, it is the finding, decision and order of the Board that the Award of Administrative Law Judge Rebecca A. Sanders dated June 25, 2010, is modified to find that claimant has a 12 percent permanent impairment of function to the right lower extremity at the level of the leg.

Claimant is entitled to 27.43 weeks of temporary total disability compensation at the rate of $416.69 per week in the amount of $11,429.81 followed by 20.71 weeks of

[14] Pratt Depo. at 27.

permanent partial disability compensation, at the rate of $416.69 per week, in the amount of $8,629.65 for a 12 percent loss of use of the leg, making a total award of $20,059.46, all of which is due and owing less amounts previously paid.

IT IS SO ORDERED.

Dated this _____ day of March, 2011.

_____
BOARD MEMBER

_____
BOARD MEMBER

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BOARD MEMBER

DISSENT

The undersigned would affirm the findings and conclusions of the ALJ. Generally, the Board gives some deference to an ALJ's determination of a witness' credibility, particularly where the ALJ had the opportunity to observe the witness testify in person. In this case, the ALJ apparently found the claimant to be credible. We find no compelling reason to find otherwise. In addition to claimant's testimony and the expert opinion testimony of Dr. Murati, the court-ordered independent medical examiner, Dr. Pratt, found claimant to have a rateable permanent impairment of function to his back and, based on a reasonable degree of medical probability, he attributed that impairment to claimant's altered gait.

> Q. [by Claimant's attorney] And within a reasonable degree of medical probability you concluded that Mr. Hughes' 5 percent whole person impairment for a DRE Category 2 lumbosacral condition was a result of his altered gait?
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> [Respondent's attorney] I'm going to object. I believe that misstates the Doctor's prior testimony.
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> [Claimant's attorney] No, it doesn't.

Q. [by Claimant's attorney] Go ahead, Doctor.

A. That was correct.[15]

Claimant denied having problems with his right knee, other than having cellulitis about two months before the accident, and denied having problems with his back before his accident at work on September 6, 2008. The altered gait continued even after claimant reached maximum medical improvement following his knee surgery. All three doctors who examined claimant after he was released from treatment by Dr. Lepse, to-wit: Drs. Gilbert, Murati and Pratt, noted that claimant had a limp or an altered or antalgic gait.

Like the ALJ, we find the opinion of Dr. Pratt persuasive on the question of causation and permanency of claimant's back condition. Accordingly, we would affirm the ALJ's finding of a general body disability and work disability under K.S.A. 44-510e.

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BOARD MEMBER

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BOARD MEMBER

c: George H. Pearson, Attorney for Claimant
Nathan D. Burghart, Attorney for Respondent and its Insurance Carrier
Rebecca A. Sanders, Administrative Law Judge

[15] Pratt Depo. at 27.